HIV variant WK.55647.362514.463792

Since COVID-19 has brought more attention to the question of virus variants and the question if every variant has the same pathogenic potential, we would like to ask, what that question means for other so called pandemics, here for HIV. One can easily estimate a lower bound of the number of all observed HIV variants until today. The actual number will be higher.

For this assessment a publication by HIV (co-)discoverer and Nobel Prize winner **Françoise Barré-Sinoussi** can be used,

- Barré-Sinoussi et al., "*Expert consensus statement on the science of HIV in the context of criminal law.*", J Int AIDS Soc. **2018** Jul;21(7):e25161, https://www.ncbi.nlm.nih.gov/pubmed/30044059

"Mutations of the virus occur repeatedly so that every person living with HIV has more than one virus variant [154]. During transmission, a limited number of virus variants (one to a few) are transmitted, ***but these will also mutate to form new variants so that no two persons' HIV is identical*** *[155*].

Every single so-called "*HIV infection*" represents a different variant and every person measured HIV+ carries more than one variant.

Virus eminence **Anthony Fauci** spoke in 2019 of over 35 million people who are said to have died some years after a positive HIV test (*slow virus* hypothesis) and of more than 77 million people who have been infected worldwide since **1981**,

- Schwetz and Fauci, "*The Extended Impact of Human Immunodeficiency Virus/AIDS Research*", J Infect Dis. **2019** Jan 1; 219(1): 6–9, Published online 2018 Aug 28, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6455931/

"The first cases of AIDS were reported in the United States ***37 years ago****. Since then,* ***>77 million people have been infected worldwide****, resulting in over 35 million deaths."*

That brings us to at least 77 million variants in the last 41 years. If we assume at least 2 variants per person ("*more than one*"), we end up in a region of ***at least 150 million variants***.

For a virus with a total genome of about **9000** base pairs, that is an enormous amount of mutations, insertions and deletions. And every time it is supposed be the same pathogen?

In connection to the *HIV=AIDS* dogma, one cannot take 2 statements made almost simultaneously and put them together without significant contradictions arising. This is the hallmark of a failed theory.

Even if one assumes the unproven and false virus hypothesis of the *AID syndrome*: the question of how many variants of HIV are there, how do they differ and whether all variants are equally

dangerous has not been asked for 38 years. Are there variants of HIV-1 and HIV-2 that are no longer pathogenic about **90 years after the assumed zoonosis**, almost simultaneously for 3 monkey species (see below)? What does this mean for the so-called HIV test? How can you even access the pathogenicity of a *slow virus* that is supposed to show its effects 15 - 20 years after infection?

Arguments and questions of this kind have been blocked for more than 30 years. They collide with the career dreams and the world-savior fantasies of the HIV super-scientists.

For years, **Brian Foley**, **Bette Korber** and **Beatrice Hahn**, who are largely responsible for the zoonotic nonsense of HIV, together with Andrew Rambaut and others, have published a catalog of several **thousand** of so-called HIV *reference* sequences.

- Foley et al., „*HIV Sequence Compendium 2018*“, Jun 27, **2018**, Los Alamos National Lab. (LANL), Los Alamos, NM (United States), https://www.osti.gov/biblio/1458915-hiv-sequence-compendium

This is supposed to give the impression that one is dealing with a defined pathogen. Leaving aside the (important) questions of virus isolation and virus detection for the moment (because they always lead to the terrible slander of "virus denial"), the bottom line is the following fact: ***what one is dealing with in case of HIV are only positive tests that respond to any number of different viral sequences***. That is all. Healthy people do not show any symptoms for years after a positive HIV test. There is only the unproven but very convenient *slow virus* hypothesis. If they do not start with the so called “*antiretroviral therapy*” (ART), they will never show any symptoms. Unfortunately, most do not have the mental strength to withstand the enormous social pressure to take this highly toxic “*medication*” and then they become sick, see below.

But these arbitrary tests are enough, also thanks to the immense media pressure, to be sentenced to a lifelong, ultimately lethal therapy. HIV (not AIDS!) is still the only "disease" that becomes chronic in 100% of treated cases.

For the virus madness, it doesn't really matter whether the zoonosis hypothesis (see below) is correct. It is enough to assume it. By the end of 2017, after at least 36 years of an alleged deadly pandemic, a little over 8500 HIV viruses had been (nearly) completely sequenced, see ibid. Foley *et al*.

*“The number of near complete genomes (>7000 nucleotides) increased to **8531** by end of 2017.”*

That's a long way from 150 million or even 77 million. But it is obviously enough not to question the virus hypothesis of the *AID syndrome*. That's an oddly low number of (near) full genome sequences for a supposedly deadly virus thought to threaten the very existence of mankind. But, according to the further assumption, thanks to modern medicine, this danger has been averted. Woe to anyone who doubts that.

What actually happens is that one simply omits the theory-falsifying investigations and considerations. Even for a "quasi" species, as viruses are also called, the enormous number of

variants of the HI virus is highly problematic, because at the molecular level the same or at least a very similar mechanism must take place in each variant. Here "science" saves itself, as it is still not known how the HI virus is supposed to lead to the *AID syndrome*. This lack of knowledge has been withheld from the public for the last 30 years.

- Coffin, Swanstrom, "*HIV Pathogenesis: Dynamics and Genetics of Viral Populations and Infected Cells*", Cold Spring Harb Perspect Med. **2013** Jan; 3(1), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3530041/

"HOW DOES HIV-1 CAUSE AIDS? A*s is apparent from this article and the rest of the collection,* ***in the 25+ years since its discovery****, we have learned an enormous amount about HIV,* ***but we still cannot answer the one big question****: How does HIV-1 cause AIDS?"*

"*Even if we knew the mechanism of HIV-mediated cell killing,* ***we would not know how HIV-1 causes CD4$^+$ T-cell decline and AIDS in humans.*** *The observation that virus and cell turnover rates in various SIVs in their natural hosts (such as SIV$_{sm}$ in sooty mangabeys),* ***which do not progress to AIDS****, are essentially identical to those in humans, who do progress, implies that cell killing alone cannot account for AIDS pathogenesis. Indeed, this result is consistent with the* ***high natural turnover rate of activated effector memory helper T cells, the primary target for HIV-1 infection, on the order of 10^{10} cells per day, of which only a small fraction are infected after the initial primary infection phase****."*

All computer simulations are based on a few selected "reference" virus sequences that have ceased to exist in nature since a long time and that exist only in the gene database.

And anything that contradicts the virus hypothesis does not reach the gene databases. This keeps the number of "reference" sequences small and, superficially, it appears that there are no contradictions in the theory. Dr. Brian Foley, the custodian of the HIV gene sequence database at Los Alamos National Laboratory, has refused to discuss this issue for the last 25 years. Until today, no one in the media has asked him how he came up with this tiny number of "references" given the huge number of variants.

But, since the 1980s, antibodies against HIV have been declared ineffective and those affected are been treated for the rest of their lives, for around €1,000 per month. Even 4 decades later, anyone who questions this will be excommunicated for asking "unscientific" questions.

See on the assumption of the unproven and more than questionable *slow virus* hypothesis,

- *Fauci et al. "Immunopathogenic Mechanisms of HIV Infection*", Ann Intern Med. **1996**; 124(7), p. 654-663, http://annals.org/aim/fullarticle/709558/immunopathogenic-mechanisms-hiv-infection

"*The duration of clinical latency varies, but progression to the acquired immunodeficiency syndrome typically occurs* ***after a mean of approximately 10 years****."*

See also the unproven and not even plausible zoonotic hypothesis,

- "*Medical Microbiology*", Jawetz, Melnick and Adelberg, 26th Edition, **2013**, p. 656,

"Origin of AIDS – HIV in humans originated from cross-species infections by simian viruses in rural Africa, probably due to direct human contact with infected primate blood. Current evidence is that the primate counterparts of HIV-1 and HIV-2 were transmitted to humans in multiple (at least seven) different occasions. Sequence evolution analyses place the introduction of SIVcpz into humans that gave rise to HIV-1 group M ***about 1930****, although some estimates push the date back to about 1908. Presumably, such transmissions occurred repeatedly over the ages, but particular social, economic, and behavioral changes that occurred in the mid 20th century provided circumstances that allowed these virus infections to expand, become well-established in humans, and reach epidemic proportions."*

- Hahn et al. "*AIDS as a zoonosis: scientific and public health implications*.", Science. **2000** Jan 28; 287(5453):607-14, https://www.ncbi.nlm.nih.gov/pubmed/10649986

"*Evidence of simian immunodefciency virus (SIV) infection has been reported for 26 different species of African nonhuman primates. Two of these viruses, SIVcpz from* ***chimpanzees*** *and SIVsm from* ***sooty mangabeys****, are the cause of acquired immunodefciency syndrome (AIDS) in humans. Together, they have been transmitted to humans* ***on at least seven occasions****."*

"How the AIDS epidemic actually began, what the contributing factors were, and ***why it appeared in the mid- to late 20th century (and not before) are not known****. Whatever the final answers are, they must account for*

(i) at least seven separate introductions of SIVcpz and SIVsm viruses into humans;
(ii) the fact that the HIV-1 group M, N, and O viruses are significantly more closely related to SIVcpz viruses from P. t. troglodytes than to the single SIVcpz isolate from P. t. schweinfurthii; and
(iii) ***the estimation of 1930 (range 1910 to 1950) as the timing of the last common ancestor of the HIV-1 group M viruses.****"*

Due to the *slow virus* hypothesis an assumed zoonosis around 1930 in Africa is necessary in back calculation from 1981 in order to explain a presumed pandemic in a population of severely drug-addicted, multiple classically infected homosexuals in the USA in the 1980s. Because before 1981 there was no AIDS.

Due to the widespread distribution of lentiviruses in the animal kingdom, it is much more plausible that a transmission to humans took place thousands of years ago, or that humans inherited HIV from their evolutionary ancestors. SIV in monkeys is believed to be several million years old,

- Compton and Emerman, "*Convergence and Divergence in the Evolution of the APOBEC3G-Vif Interaction Reveal Ancient Origins of Simian Immunodeficiency Viruses*", PLoS Pathog 9(1): e1003135, Jan 24, **2013**, https://journals.plos.org/plospathogens/article?id=10.1371/journal.ppat.1003135

*"The pattern of adaptive mutation suggests that SIV has been infecting OWM **on timescale of millions of years**."*

And what do the numerous variants mean for the HIV test? What exactly does this test even measure if each so-called "infected" person carries a different variant?

Nobody knows, nobody asks, nobody cares. And this despite the fact that the ***lifelong***, so-called HIV therapy leads to numerous serious tissue damages and ultimately to death, cf.

- HIV.gov, "*Adverse Effects of Antiretroviral Agents*", Jun. 03, **2021**, https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/adverse-effects-antiretroviral-agents

or

https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/AdultARV_GL_AdverseEffects.pdf

Bleeding Events
Bone Density Effects
Bone Marrow Suppression
Cardiac Conduction Effects
Cardiovascular Disease
Cholelithiasis
Diabetes Mellitus and Insulin Resistance
Dyslipidemia
Gastrointestinal Effects
Hepatic Effects
Hypersensitivity Reaction
Excluding rash alone or Stevens-Johnson syndrome
Lactic Acidosis
Lipodystrophy
Myopathy/Elevated Creatine Phosphokinase
Nervous System/Psychiatric Effects
Rash
Renal Effects/Urolithiasis
Stevens-Johnson Syndrome/Toxic Epidermal Necrosis

This list is too short than too long considering that some overly toxic substances such as **didanosine** (ddI), **stavudine** (d4T), **fosamprenavir** (FPV), **indinavir** (IDV), **nelfinavir** (NFV), **saquinavir** (SQV) and **tipranavir** (TPV) are no longer in use. Before that, they were in use for years, with disastrous consequences for the people treated with them.

Virtually all people diagnosed with HIV+ have been and will be treated with these highly toxic substances at some point in their remaining lives, most for the rest of that life.

- Joint United Nations Programme on HIV/AIDS, "*Global HIV & AIDS statistics fact sheet*", access Feb **2022**, https://www.unaids.org/en/resources/fact-sheet

"***28.2 million people*** *were accessing antiretroviral therapy as of 30 June 2021*"

After a few years of "therapy", all of these 28.2 million people suffer from at least one, usually several, of the side effects described.

- Maggi et al., "*Clusterization of co-morbidities and multi-morbidities among persons living with HIV: a cross-sectional study.*", BMC Infect Dis. **2019** Jun 25;19(1):555, https://www.ncbi.nlm.nih.gov/pubmed/31238916

"Non-HIV co-morbidities included: ***cardiovascular disease***, ***diabetes mellitus***, ***hypertension***, ***oncologic diseases***, ***osteoporosis***, *probable case of chronic obstructive pulmonary disease (COPD), hepatitis C virus (HCV) infection,* ***psychiatric illness***, ***kidney disease***."

"Table 1 - Characteristics of 1087 patients enrolled in the Cluster Project: ***Years since ART initiation 9.0*** *(4.0–16.0)"*

"The most frequent co-morbidity was ***dyslipidemia*** *(55.3%), followed by* ***hypertension*** *(31.4%), COPD (29.4%), hepatitis C virus (HCV) infection (25.4, 5.5% with detectable HCVRNA),* ***psychiatric illness*** *(10.3%), diagnosis of* ***osteopenia/osteoporosis*** *(10.1%),* ***diabetes*** *(6.1%), and* ***renal impairment*** *(4.8%); 95 (8.7%) subjects had history of* ***non-AIDS-defining cancer****. Forty-nine patients (4.5%) had* ***pCVD events****."*

"Our data evidence that, in spite of mean age lower than 50, ***co-morbidity was the rule among our PLWH (82%), and that more than 50% of our patients were multi-morbid****. Moreover, about 30% of them had three or more chronic non-HIV related conditions, thus confirming recent data provided by other studies in the field."*

- Hernández et al., "*Increased incidences of noninfectious comorbidities among aging populations living with human immunodeficiency virus in Ecuador: a multicenter retrospective analysis*.", HIV AIDS (Auckl). **2019** Apr 1;11:55-59, https://www.ncbi.nlm.nih.gov/pubmed/31114389

"The average age at HIV diagnosis was 34.1 years old and cART in average was started 15.9 months after HIV-diagnosis. ***Recruited patients were receiving cART for an average of 59.2±40.2 months. Only 9.9% (n=50) of the patients did not show any NICMs [noninfectious comorbidities]****. Diabetes and pre-diabetes was found in 6% (n=30) and 16.3% (n=82) patients, respectively; however, dyslipidemia and overweight/obesity was frequent, as they affected 41.4% (n=208) and 36.4% (n=183) patients, respectively."*

*"Conclusion**: Prevalence of NICMs among subjects under cART was greater than that reported among the Ecuadorian general population**, therefore specific public health actions are required to make patients aware of and prevent NICMs among PLHIV in Ecuador."*

But it's a gigantic industry. What is never said about it: the doses have been drastically reduced in the past 3 decades. Lo and behold, those poisoned in this way live longer. Nobody(!) survives 1500 mg AZT (zidovudine) per day(!), as it was used in the terrible Burroughs Wellcome experiment in 1986/87, see Kreis (2022) with further references,

- Johannes Kreis „*AIDS 2.0 Deadly Compassion*", Feb 12, **2022**, https://archive.org/details/aids-2.0-deadly-compassion

and

- Johannes Kreis „*HIV – Where the disaster began*", Feb 23, **2022**, https://archive.org/details/hiv-where-the-disaster-began

Why was no one allowed to question the *HIV=AIDS* dogma in the last 38 years? Why were all critics of the *HIV=AIDS* dogma excommunicated by the so-called *scientific community*?

There are very obvious questions that have remained unanswered for decades, e.g. on the *bystander cell problem*, i.e. far too few CD-4 cells of the immune system are infected with HIV to cause a drop in the CD-4 cell count and thus lead to a weakening of the immune system in severely drug-dependent and multiply infected patients (the real *AID Syndrome* patients), see above and,

- Finkel et al. „*Apoptosis occurs predominantly in bystander cells and not in productively infected cells of HIV- and SIV-infected lymph nodes.*", Nat Med. **1995** Feb;1(2):129-34, https://www.ncbi.nlm.nih.gov/pubmed/7585008

"*We show here, using in situ labelling of lymph nodes from HIV-infected children and SIV-infected macaques, that apoptosis occurs **predominantly in bystander cells and not in the productively infected cells themselves**."*

Since 1995, there has been no advance in answering this question, cf.

- Garg, Joshi, „*Host and Viral Factors in HIV-Mediated Bystander Apoptosis*.", Viruses. **2017** Aug 22;9(8), https://www.ncbi.nlm.nih.gov/pubmed/28829402

"*With a limited number of infected cells and vastly disproportionate apoptosis in HIV infected patients, it is believed that apoptosis of **uninfected bystander cells** plays a significant role in this process."*

"***The number of HIV infected cells in patients is relatively low*** *and cannot solely account for the loss of CD4 cells in vivo. Hence, it is believed that the loss of CD4 cells during HIV infection is due to the process of bystander apoptosis induction."*

*"**Apoptosis mediated by HIV infections is more complex than previously thought**. A role of both host and viral factors in this phenomenon is becoming increasingly evident."*

Because the answer is that HIV has nothing to do with the *AID Syndrome*.

For 3 decades the noble writers of "science journalism" refuse to ask critical questions on the *HIV=AIDS* dogma. On the contrary, many have participated and continue to participate in the hunt for the critics of the viral dogma of AIDS.

In the meantime, the *HIV=AIDS* hardliners and the Stone Age AIDSers in "science" are up to their necks in water. Because the contradictions can no longer be swept under the carpet. And it is clear to every citizen that the panic story of the killer viruses that supposedly are plaguing mankind again and again for 40 years (HIV, various bird and swine flu viruses, SARS, MERS and also BSE) is not true.

So the elite scientists indulge in perseverance slogans.

- *„Was passiert nach Omikron? Protzer: Rückkehr von Delta "absolut möglich""*, n-tv, 31.01.**2022**, https://www.n-tv.de/panorama/Protzer-Rueckkehr-von-Delta-absolut-moeglich-article23094004.html

Translation
[*„What happens after Omirkon? Protzer: return of Delta „absolutely possible"*]

- *„Lauterbach: Pandemie kann noch zehn Jahre dauern"*, FAZ.NET, 19.02.**2022**, https://zeitung.faz.net/faz/politik/2022-02-19/83dc815095cdc900572e611a63e713b4/?GEPC=s3

Translation
[*„Lauterbach: pandemic may last another 10 years"*]

Mantra-like, the empty phrases about the constant threat are repeated over and over again, now that it is clear that the omicron variant of SARS-CoV2 is significantly less dangerous. Just as evolutionary biology predicts: Viruses that kill their host (i.e. the host cell) wipe themselves out.

Nobody in the so open scientific community is allowed to question the *HIV=AIDS* dogma. The consequences of the "antiretroviral treatment" were and are too terrible. So all contradictions will be ignored further. Nobody demands answers from science. HIV and AIDS have become a non-issue because everything is clear and any further question is "unscientific". No. It has been made a non-issue because the *HIV=AIDS* dogma is not even superficially plausible. It is only stabilized by massive exclusion and defamation of all critics. Now one tries the same with SARS-CoV2. In some time SARS-

CoV2 will also become a non-issue. The alleged pandemic and the catastrophic consequences of the false theories will be eclipsed behind “more important” issues of day-to-day politics.

Humanity was saved again thanks to 2 vaccinations every year. The billions in sales are a necessary evil, a toad that has to be swallowed to save the world. Only Holocaust deniers and anti-semites doubt this renewed, glorious success of so-called modern medicine.

Further References:

- Johannes Kreis „*HIV And AIDS – What Was (again) Not Said On Last Year’s World AIDS Day (update)*”, Feb 11, **2022**, https://archive.org/details/hiv-and-aids-what-was-again-not-said-on-last-years-world-aids-day-update